

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048049

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6504

FILED DEC 19 1963

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2 3828

3

4 1

5 2

6

7 0

8 2

9 331x

10

11

12 67-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Michael Bernreiter MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If outside, give location) 6152 Locust	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST THERESA M HEUSER		4. DATE OF DEATH Month Day Year December 1, 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-16-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Manager		10b. KIND OF BUSINESS OR INDUSTRY Heuser Printing Co.	
13a. FATHER'S NAME Frank X. Schaefer		13b. MOTHER'S MAIDEN NAME Ann Leibinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT Address Mrs. Frank J. Scholz 6152 Locust		14. NAME OF HUSBAND OR WIFE Herman J. Heuser	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) [redacted]		INTERVAL BETWEEN ONSET AND DEATH 4 wks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial infarction, old		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5-1-56 to 12-1-63 and last saw her alive on 12-1-63 Death occurred at St. Mary's Hosp 11:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Michael Bernreiter M.D.	
22b. ADDRESS 1018 Proj. Bldg, K.C. Mo		22c. DATE SIGNED 12/2/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-4-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town, or county) Kansas City, Missouri		23e. DATE RECD. BY LOCAL REG. 12-2-63	
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar 20 W. Linwood		26. REGISTRAR'S SIGNATURE Bessie Smith	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

Mr. Michael Bernreiter  
Prof. Bldg.  
Wa 1-0266 48

Mon: 1:30 to 4:00

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James E. Kachman

Licensed Embalmer No. 4523

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.